MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

**Thursday, March 21, 2002**
**10:10 a.m.**

COMMISSIONERS PRESENT:

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ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

**AGENDA ITEM: Supplementing Medicare's benefit package: Medicaid, Medigap and retiree health insurance, and the role of Medicare+Choice**
**-- Jeanne Lambrew, George Washington University;**
**Scott Harrison, Susanne Seagrave, Chantal Worzala**

DR. WORZALA: At the last meeting, you discussed some of the limits of the Medicare fee-for-service benefit package. During this presentation, we want to provide you with information about the ways in which beneficiaries are obtaining coverage for cost-sharing requirements and also for some uncovered benefits.

I want to start by introducing our guest lecturer, Jeanne Lambrew. Jeanne is an Associate Professor of Health Services Management and Policy at George Washington University. Most of you probably know Jeanne. For those who don't, she has considerable experience working on Medicare, Medicaid, and other health policy issues.

She worked at the White House from 1997 to 2001 as the Program Associate Director for Health at the Office of Management and Budget. She was also Senior Health Analyst at the National Economic Council. Prior to serving at the White House, Dr. Lambrew taught at Georgetown University and worked at the Department of Health and Human Services.

Turning to the topic at hand, I will begin the presentation by discussing why the topic of additional coverage is important. I'll then turn the discussion over to Jeanne, who will discuss sources of additional coverage and some of the recent trends in how beneficiaries are filling Medicare's cost-sharing obligations and obtaining additional benefits.

And then Scott is going to wrap up the presentation with a discussion of the issues you may want to consider when contemplating changes to the benefit package.

We know that fee-for-service Medicare has significant cost-sharing obligations and limited coverage for some items, such as prescription drugs. As Ariel will discuss later, we estimate that the Medicare program currently pays about 60 percent of beneficiaries' total health care costs, if you exclude long-term care costs.

To help cover those costs that aren't borne by the program, over 90 percent of Medicare beneficiaries obtain coverage beyond the fee-for-service benefit. They do this either by supplementing it with additional source of coverage or by replacing it with a managed care plan.

On a semantic note, we tried to refer to sources of additional coverage as a broad term that would include Medicare managed care and use the term supplemental coverage for those products that truly are a supplement to fee-for-service Medicare. But we will probably slip in that, so please bear with us if we use the terms interchangeably.

It's important to understand beneficiary sources of

additional coverage for a number of reasons. First, beneficiaries without a source of additional coverage report more coverage with access to care. For example, in 1998, those with only fee-for-service Medicare coverage were more than three times as likely as those with fee-for-service Medicare and private supplemental insurance, to report trouble getting care. They were nearly five times as likely to delay getting care due to cost, and more than three times as likely to lack a usual source of care.

In addition, they were more than 2.5 times as likely to have not visited a doctor's office in the past year, compared to those with private supplemental insurance.

In terms of the actual percentages, I'll only elucidate one of those numbers. That is that 21 percent of those with only Medicare fee-for-service coverage reported delaying care due to cost, compared to 4.4 percent of those with private supplemental coverage. That's from previous MedPAC analysis of the MCBS access to care file for 1998.

We, of course, cannot infer that those with private supplemental coverage have the optimal level of service use, but the magnitude of these differences does suggest that those without supplemental coverage are more likely to have access problems.

Recent research has also suggested that having supplemental coverage is associated with greater use of medically appropriately therapies, and especially drugs, for certain medical conditions. For example, beneficiaries with coronary artery disease were more likely to take statins if they had supplemental coverage that included drugs.

We plan to bring you new findings on the associations between sources of additional coverage and access to necessary care at the April meeting. So we'll have 1999 findings, at least.

Finally, we want to look at supplemental coverage in particular, and here I do mean those things that really supplement the fee-for-service package, because they complicate and distort the market. Studies have shown that beneficiaries lack a basic understanding of the Medicare program and they have considerable difficulty navigating the many choices of how to obtain additional coverage.

In addition, the multiple sources of coverage do increase administrative expenses in processing claims and managing multiple systems. And for those purchasing private supplemental coverage on an individual basis, that's simply a very expensive way to get insurance.

Finally, some supplemental products provide generous coverage of Medicare's cost-sharing requirements. Most products do pay for the lion's share of beneficiaries' deductibles and coinsurance, and some of the products cover all of them. That's what we mean by first dollar coverage because beneficiaries are protected from financial liability from the first dollar of expenditure beyond their premium.

These products then eliminate the incentives for judicious use of services that cost-sharing is meant to provide. While studies of this effect vary on the magnitude, there is general consensus that use of services is increased when first dollar coverage is provided.

MS. ROSENBLATT: Excuse me, could we just mark this slide. I have a lot of comments on this one later.

DR. WORZALA: If you'd like, we can address them now. I don't have a problem with that.

This increased use of services results in higher premiums for beneficiaries and higher costs for the Medicare program. I do want to note that the literature has observed this relationship but it doesn't identify how much of the additional service use or, of course, which specific services might be considered unnecessary. And in light of the evidence that we have regarding access to care, it's not clear that the level of services used by those without supplemental coverage should be considered optimal in any way.

At this point I'm going to turn things over to Jeanne and she'll take it from there.

DR. LAMBREW: I think that, given the interest in the other commissioners' asking questions, I'm going to try to do a very quick overview of the different sources of supplemental coverage, the differences across types of supplemental coverage, and then the characteristics and trends in the sources of supplemental coverage.

About 91 percent of Medicare beneficiaries have some type of supplemental coverage for most of the year. The most common source of supplemental coverage is employer-sponsored insurance. For most Medicare beneficiaries, this means retiree health insurance. For some, they're active workers and they're included in this category.

The second most common type of supplemental coverage is Medigap. About 28 percent of Medicare enrollees in 1998 have Medigap health insurance, which is primarily individual health insurance sold in the individual market.

Third, about 18 percent of Medicare beneficiaries had Medicare managed care. I will not be politically correct in this presentation and call it supplemental coverage because it clearly was providing extra benefits and reduced cost-sharing for Medicare beneficiaries.

Fourth, Medicaid covers about one in 10 Medicare beneficiaries.

If you look at this pie chart, it's important to note that this is the coverage distribution for where they had coverage for the most part of the year. About 12 percent of Medicare beneficiaries had either different sources of coverage throughout the year or multiple sources of coverage. It's not uncommon that Medicare beneficiaries will have Medicare managed care and Medigap, as well.

This is a fairly complicated table but what it tries to do is compare the sources of supplemental coverage across three

major dimensions. First, who's eligible; second, how much you pay; and third, what's covered?

Looking at eligibility, what's interesting about supplemental health insurance for Medicare beneficiaries is that virtually all types of coverage have some type of eligibility and/or access restrictions. Clearly, employer-sponsored insurance is restricted to those who work for the particular firm, and even within those firms there's often a length of service requirement. In the year 2001, the average length of service that an individual had to work to quality for retiree health insurance was 11 years.

With Medigap, all people joining Medicare at the age of 65 have guaranteed access to Medigap for six months. But afterwards, in most states, plans can both underwrite those individuals and deny them coverage all together. In addition, those non-elderly Medicare beneficiaries are at larger disadvantage. There's only 19 states that guarantee access to Medigap for the non-elderly Medicare beneficiaries.

With Medicare+Choice, it probably has the least access restrictions up front in terms of any individual in an area can sign up for it. But, as you've heard in previous presentations, those choices have become increasingly restricted. About 40 percent of Medicare beneficiaries lack the choice of a Medicare managed care plan in the year 2001.

And finally, Medicaid has very strict eligibility criteria, in part because of its generosity of benefits, which we'll talk about momentarily.

Looking at the row on premiums, in addition to Medicare's Part B premium, which is $54 in the year 2002, what you see is that actually most beneficiaries pay something for supplemental health insurance. The average premium for employer-sponsored health insurance was $50 in the year 2001.

Not all people in retiree health plans pay premiums. About a third of them don't. But another one-fifth of those beneficiaries in retiree health insurance pay the full premiums, so this represents an average.

The Medigap premium in the year 2000 was about $108 per month. That reflects premiums across all different types of plans, including those with prescription drugs, whose average premium was closer to $130 per month. In addition to those types of variations across plan types, there's significant variation by age and geography. In many places, beneficiaries can be charged more based on their age. So that the premium that they get charged in Medigap at age 65 rises significantly when they turn 80 or 85.

That's called age attained rating. Similarly, there's significant variation across area, in terms of Medigap premiums. The Medigap premiums in California, Indiana and Florida are, on average, 20 percent higher than average and 75 percent higher than low cost states like New Hampshire, Utah, and Montana.

Even Medicare+Choice has increasingly relied upon premiums for their enrollees. The average in the year 2002 is $31.

Again, some beneficiaries pay nothing for it. Some pay higher premiums. That represents the average but it's a increasingly trend.

With Medicaid, there is no premium for most beneficiaries.

Turning to coverage, and we'll go through this fairly quickly because again this is a complicated table, virtually all types of supplemental coverage reduce Medicare's cost-sharing to either nominal rates or nothing. This represents a significant change in the out-of-pocket burden for those beneficiaries.

The variation of coverage with benefits is much greater. If you look at prescription drugs, most employer-sponsored health insurance plans and most managed care plans do offer prescription drugs to their enrollees. But in all cases, we're seeing significant restrictions. The Medigap drug benefit is availed of by only a third of its beneficiaries, and it's a capped benefit with a $250 deductible, 50 percent copays, and a cap at $1,250 or $3,000 per year. In other words, once you have $6,250 worth of drug spending in Medigap, you get no more coverage.

Similarly, as you probably heard in previous presentations, the Medicare managed care benefit has grown increasingly limited over time. In the year 2001, according to some work that Marsha Gold has done, about 30 percent of plans had no drug coverage and of those with drug coverage, nearly half had caps at or below $1,000.

Finally, Medicaid does remain a major payer of prescription drugs for Medicare beneficiaries. It does cover the full range of drugs for most Medicare dual eligibles.

Looking at the other benefits, Medicaid really is the only program that has significant long-term care coverage. Most of these sources of supplemental coverage cover dental, vision and hearing services, although that also is becoming more limited both in employer plans and in Medicare managed care. And preventive services are often covered by most of these sources of supplemental coverage.

These differences in eligibility and premiums and access appear in the distribution of Medicare beneficiaries across types of supplemental coverage. What this chart shows is that there is a very big difference in who gets what type of coverage based on income. Medicaid is the primary payer or source of supplemental coverage for those below poverty, whereas employer-sponsored coverage is the primary source of coverage for those in the higher income brackets, here defined as about $31,000 for a single and $40,000 for a couple.

What's interesting about this chart is looking at these people with medium income. About 26 percent of them purchase Medigap coverage which, for individuals at the lower end of that income spectrum, could represent about 15 percent of income not including the cost of drugs.

Turning to the next slide, we also see a variation in coverage by geography. The patterns of coverage for rural Medicare beneficiaries is quite different than that of urban beneficiaries. Part of that relates to the lower rate of

employer-sponsored coverage in rural areas. Smaller firms, self-employed individuals are much less likely to have retiree health coverage than those in other types of firms which are predominantly in urban areas.

We also see much managed care. These statistics, remember, are from 1998 so this has changed since then, and in fact worsened. But there are one-sixth fewer people in rural areas in managed care as a proportion of population than in urban areas.

This will help explain why 36 percent of Medicare beneficiaries in rural areas are in Medigap. It's a much more important source of care in rural areas than in urban areas.

Finally, it's interesting to note that twice the proportion of Medicare beneficiaries in rural areas lack any type of supplemental coverage.

Now I'll very briefly talk about a couple of characteristics of the four major types of supplemental coverage, less on Medicare managed care, before we talk about trends.

Looking at retiree health insurance coverage, not surprisingly, in the same way that large firms are more likely to offer active workers health insurance, large firms are also more likely to offer retiree health coverage. As this chart shows, 65 percent of those individuals with retiree health insurance coverage were employed by firms with 5,000 employees or more.

You also have within this, as I said previously, a difference both in geography with firms in the Northeast more likely to offer coverage than in the West, but also by type of firm. Government is the most common type of firm that offers retiree health insurance coverage. 61 percent of individuals who work for the government have this option versus 38 percent of those in financial services jobs, 27 percent of those in services jobs, and 9 percent of those in wholesale or retail jobs.

But as discussed a little bit this morning, these trends are changing. There has been a gradual decline in the percent of firms offering retiree health insurance coverage in the last eight years. Probably this isn't gradual. There's been about a 40 percent drop since 1993 in the percent of firms who offer this type of coverage.

Part of this may be due to the accounting changes that occurred in 1992 that required for employers to account for these costs on a different accrual basis. But there also may be these other factors that were discussed this morning, higher health inflation, the concern about prescription drugs.

What's interesting about this, though, is that it's not necessarily firms dropping those retirees who are already in Medicare. What we think is going on is that it's firms not offering their future retirees this type of coverage. So what that means is that this reduction in the number of firms offering coverage won't yet show up in the Medicare statistics for several years. This is something that's coming down the pipeline.

It is also important to note, in thinking about the trends, that this is a dichotomous chart, whether employers offered or did not offer. We've also seen a significant decline in

generosity. In the last two years 33 percent of the firms reported that they increased the copayments for prescription drugs and 26 percent of firms reported that they increased the retirees's share of premiums.

Turning to Medigap and the next slide, what this chart shows is the distribution of enrollment across different Medigap plan types.

I'm sorry, there is an insert that was either tucked into your packet or on the chair that you should be looking at now. Actually, the insert, I think, began on the previous slide.

What this chart shows is the distribution of Medigap enrollees across plan types. Nearly 60 percent of Medigap enrollees are in those standardized plans that offer cost-sharing. It's important to note that individually purchased Medigap policies have been around since the creation of Medicare. But given lots of concerns in the late '80s about people purchasing multiple types of plans, overlapping coverage and general consumer concerns about these plans, they were standardized in 1990. There are 10 plans, A through J. Basically A through G offer just mostly cost-sharing and some preventive benefits. H, I, and J offer prescription drugs.

Most people are in those plans that offer just cost-sharing. A small fraction have purchased that coverage that includes the limited prescription drug benefit. About one-third of Medicare beneficiaries with Medigap are either in plans that they purchased prior to the standardization of these benefits in 1990 or are in states that have been exempted from these laws.

Turning to the next slide, we also have seen a decline in Medigap enrollment in the late 1990s. Sine 1991, when 38 percent of Medicare beneficiaries were Medigap, it's dropped down to 28 percent in 1998. In fact, the insurance commissioner data suggests that the greatest drop in the last several years are in those plans that cover prescription drugs.

One explanation for this drop is that those people who were paying those premiums for prescription drugs moved to Medicare managed care. In many areas, it was an affordable option with a generous drug benefit. However, since 1998, with the changes in the structure of Medicare managed care, it's much less clear what has happened in the Medigap market. In fact, some work that Scott's done suggests that there may actually be an increase again in the number of people enrolled in Medigap since Medicare+Choice has declined.

Turning to the next slide, it is actually mislabeled. It's the distribution of beneficiaries enrolled in Medicare and Medicaid in 1999.

What this shows you is what different types of what are called dual eligibles get. Medicaid is a fairly complicated program but basically you can think about it as who gets what benefits. There's a subset of people who get full Medicaid benefits, known as full dual eligibles. On this chart it says that 57 percent of those people in Medicare and Medicaid are full dual eligibles and get prescription drugs, long-term care, and

Medicaid's other benefits.

About 11 percent are eligible only for premium and cost-sharing assistance through what are called the Qualified Medicare Beneficiary and SLIMB programs. What that means is that you have income below 100 percent of poverty, you get all Medicare's cost-sharing and premiums paid for. And if you have income between basically 100 and 120 percent of poverty, you get your Medicare Part B premium covered by Medicaid. Again, a small fraction of enrollees are in those programs.

The third big other category partly is just states reporting another category. So some of these people may be fully dually eligible and be getting prescription drugs and long-term care.

Some of them may also be in waiver programs. There's a third category of Medicaid coverage which is partial benefits. People in what are called 1915(c) waivers get home and community-based care if they would otherwise be eligible for nursing homes. We've begun to see at rend in states of covering prescription drugs only through 1115 waivers, and we think that some state coverage also gets captured in this category.

What's important to note is that this pie that shows the enrollment represents only a fraction of those people eligible. About 25 percent of Medicare beneficiaries could be eligible for Medicaid assistance in one form or another, but only a small fraction participate. Estimates suggest that only 45 to 55 percent of those eligible for full Medicaid will participate in that option. The percentage drops precipitously when you just look at that cost-sharing protections. One study found that only 15 percent of those eligible for Medicare's premium assistance, Part B assistance, participated in that program.

These trends may change over time. In the 1990s we saw basically a fairly steady component of Medicaid spending accounted for by dual eligibles. In fact, it's interesting to note that in 1998 the 17 percent of Medicare beneficiaries who are dual eligibles -- those are both in institutions and in the community -- accounted for 28 percent of Medicare spending. These are high users. But projections are suggesting that we're going to see a much greater increase in Medicaid spending associated with dual eligibles.

A recent analysis found that over half of the increase in Medicaid spending between the years 2000 and 2001 was accounted for by the aged and disabled. Part of this may be long-term care as those costs begin to creep into the system, but prescription drugs clearly accounted for a lot of this increase, as well. Aged and disabled Medicaid beneficiaries accounted for 80 percent of Medicaid drug spending in the most recent year. And they have the highest utilization of prescription drugs of all Medicare beneficiaries. So a smaller proportion of population, but a high cost population that's only growing over time.

Turning to the next slide, I'm going to just very quickly talk about the Medicare managed care trends. As you, I think, heard in your December meeting, we have seen a peak and a decline in the percent of the Medicare population enrolled in Medicare

managed care. This has an interrelationship between what happens in other types of coverage. Where did these people go? We'll talk a little bit about that in a couple of minutes.

Turning to the next slide, we also note in the same way that employer-sponsored insurance is becoming less generous. We also know that Medicare managed care plans are covering less of beneficiaries' cost-sharing liabilities. Premiums have increased, cost-sharing for most services has increased, including that of prescription drugs. And there are some plans that have discontinued covering brand name prescription drugs at all.

In closing, what we do know is the good news, is that most beneficiaries have some type of supplemental coverage. For the most part, this supplemental coverage does a good job at helping seniors pay for the cost-sharing liability that's not covered by Medicare. But I think that Marsha referred earlier to her crystal ball. I'm actually more likely probably than Marsha to bet, but I am in this case absolutely not going to predict what might happen because there are very complicated trends going on in this area.

Can those people losing Medicare+Choice coverage get affordable Medigap coverage is an important question. What will happen as those people who no longer are offered retiree health insurance coverage enter the system? That's another question. I think that the pressure on states, there was a question earlier about whether or not states are going to begin reducing their coverage for dual eligibles in light of their state budget crises.

The good news there is that most states can't. Most of these programs are mandatory and that's good news from a federal perspective, I think. But the bad news is that we do have abysmal participation in these Medicaid programs. So the extent that that participation declines even further because states are just not willing to sign these people up, we may also see a diminution in that type of coverage.

The bottom line is most experts do agree that there will be a bigger share of Medicare beneficiaries who lack any type of supplemental coverage. But beyond that, I think it's guesswork.

DR. HARRISON: Given that so many beneficiaries have one form or another of supplemental coverage, policymakers should consider how the supplemental coverage would affect the outcomes of any proposed benefit changes. One set of issues would relate to how the proposed benefit change would overlap with supplemental policy benefits. Another set would relate to how the change would affect the supplemental markets. In addition, there are administrative issues that should be examined. For each set of issues here we pose some questions and give brief answers for different illustrative benefit changes.

My intention here is that we focus on the type of questions that should be asked and on the type of analyses that should be done, not on the particular responses that I use here to illustrate the process.

Jeanne just told you how varied supplemental coverage is and widespread. Almost any conceivable benefit expansion will create an overlap with some existing supplemental coverage. Let's look at overlap questions that should arise when evaluating a benefit expansion proposal, and I'll use outpatient prescription drugs as an example here.

How many beneficiaries would have overlapping coverage? I think in some of Jeanne's work she found that close to 70 percent of Medicare beneficiaries recently had some coverage for outpatient prescription drugs.

What are the characteristics of beneficiaries who would tend to have duplicate coverage? For prescription drugs, those beneficiaries who are eligible for Medicaid have drug coverage, and those with employer-sponsored plans usually have drug coverage. Those with Medigap and those in Medicare managed care plans sometimes have drug coverage. Some of this coverage may, in fact, be more comprehensive than any proposed benefit. Medicaid drug coverage is comprehensive with only nominal copayments. Some employer-sponsored coverage is similar.

These overlap questions would be important to policymakers that were concerned about benefit expansion crowding out private coverage.

Before I move on, there's another question related to overlap and how would beneficiaries respond to a new benefit design that supplemental policies may overlap by filling in copayments and deductibles? If a drug benefit were designed with the idea that copays would help keep beneficiaries from overutilization, and those copays were effectively eliminated through supplemental coverage for many of the beneficiaries, much of the rationale behind the copayment structure would be defeated and Medicare costs would rise more than expected.

Let's move on to the question of how a change in the benefit packages might affect supplemental insurance markets. For this set of questions, let's assume that the proposed benefit change is to lower Medicare cost-sharing for outpatient services.

How would the change affect the price of supplemental insurance? If beneficiary copayment liability were reduced, presumably the cost of policies that cover these copayments would decline. Medicaid, Medigap, and employer-sponsored plans might all become less costly.

Who would benefit from these lower costs? In the case of Medicaid, the states would benefit from lower costs while lower federal government costs for Medicaid would probably be offset by higher federal costs to pay for the benefit expansion.

Assuming that Medicaid markets are competitive, the lower costs should be translated into lower premiums for enrollees. Figuring out who realizes savings for the employer-sponsored plans is much tougher. Employer savings could go to their bottom line, or they could pass some or all of the savings on to their retirees, or they could pay current workers more since the cost of the future benefit obligations would be lower.

How these changes in the cost of supplemental products and

the changes in the financial risk borne by beneficiaries would affect the demand for supplemental products is also uncertain. There would generally be some trade-off between the lower prices and lower expected beneficiary liability. The lower prices should increase demand, but the lower threat of out-of-pocket costs could end up lowering demand.

The last set of questions I'll mention today deal with thinking about administrative issues. To illustrate this series, we'll assume the proposed change would combine the A and B deductibles and include a catastrophic cap. I'm going to skip over all the implementation problems that would arise from that, but try to look at it from the point of view of the beneficiaries.

For beneficiaries and supplemental insurers, such a change might produce a simpler system. Beneficiaries and their insurers would only have to keep track of one deductible and they would no longer have to keep track of spells of illness. Some beneficiaries currently have supplemental coverage that covers one deductible but not the other.

If there were a catastrophic cap, then some beneficiaries might feel that their risk was low enough to forego supplemental insurance. If they had no supplemental coverage, they would not have to worry about benefit coordination and bill submission.

The system as a while might also be more efficient for those who continue to supplement Medicare because once a beneficiary reached the catastrophic cap, the supplemental insurer would no longer have to process claims for that beneficiary. Similarly, beneficiaries might not send Part B claims to supplemental insurers until they had reached the presumably higher deductible. Overall, there would be fewer claims that would have to be submitted to multiple insurers.

Finally, would a proposed change affect the ability of the supplemental market and Medicare to get a fair selection of beneficiaries? With a catastrophic cap, it is likely that the price of Medigap plans would decline because the supplemental insurers would no longer be at risk for beneficiaries with very high costs. A lower price means that more healthy people might be willing to buy it because they think they have more of a chance of recouping the premiums.

On the other hand, if a supplemental plan covered the combined deductible, a greater share of the total plan expenditures would go for first dollar coverage. That could increase the dollar trading nature of the policy and lead to higher costs, which could make it harder for the plan to get fair selection.

So I've just used a couple of different possibilities as illustrations and now we're open for discussion.

MR. HACKBARTH: Okay, Jack.

DR. ROWE: I defer to the distinguished representative from Thousand Oaks, California.

MR. HACKBARTH: No, I'm looking away.

MS. ROSENBLATT: I have some real good points here. First

of all, on the introduction to this chapter, I'm going to read it. It said comments should focus on tone and content. So I am going to make some comments about tone.

To illustrate the tone, could we see the chart that says supplemental coverage complicates and distorts the market? I believe that there's a heading in the chapter that says the same thing. To me, that is a tone issue. 20-some-odd percent of individuals in the market are buying these policies. I think that we need to change the tone, so that we're not coming out with comments like complicates and distorts the market.

Could we then go to the chart that has the differences across sources of supplemental coverage?

DR. ROWE: What words would you choose? Why do you feel, assuming that you or Murray or someone will consider Alice's suggestion, why would you feel that it complicates and distorts the market? Why would you feel that way, Chantal? Even if we talk you out of using those words, obviously that's the way you felt. Why would you feel that?

DR. WORZALA: I would say that the word complicate is mostly just a descriptive, as opposed to normative, phrase. It's just complicated because beneficiaries have to navigate all these difference choices and do a patchwork. That's not necessarily something that's a characteristic of supplemental coverage. And so ascribing it to supplemental coverage is probably the wrong way to do it. The system as a whole is complicated for beneficiaries.

So I wouldn't attribute that complication to supplemental products, because they are clearly filling a need for beneficiaries.

MS. ROSENBLATT: I agree with what you just said, but what's in the text is making it sound like it's the supplemental coverages that are doing that, that are causing the complication and the distortion.

DR. WORZALA: I definitely appreciate that comment. You can't always pick those things up when you're writing it, so that's very important feedback. I don't mean that it's those products that are complicating it. It's the whole system that's complicated and they are, in fact, filling a very important role, I think, in protecting beneficiaries from out-of-pocket liability.

On the distorting the market, it sort of comes out of the economic literature. What it's really referring to, and again I'm happy to be more explicit in what I'm saying and not use that word, I don't have any problem with it. But it's this notion that you put in cost-sharing obligations to give people incentives to use services judiciously. And then you tweak those incentives by offering first dollar coverage. That's the distortion because you're distorting the economic incentive.

I don't mean it in a pejorative sense at all. It's just sort of an economics term and I'm happy to change it.

MS. ROSENBLATT: What you're talking about is a well-known actuarial principle, that the richer the benefit the greater the

utilization you get, the less rich the benefit the lower the utilization will be. And I would agree with that.

But in terms of tone, the reason the products exist the way they do today is due to OBRA. We've had over 10 years of no changes to the benefit structure. If there had been a free market allowing changes to the benefit structure, there might be totally different products out there right now. So that's another tone issue, where I think the OBRA law was intended to fix certain things and had a whole bunch of unintended consequences that we're seeing today.

MR. HACKBARTH: Perhaps a more neutral term would be alters decisions that beneficiaries make. There is an ambivalence in the presentation. On the one hand, we observe that beneficiaries that have various types of additional coverage use more services or are more likely to receive appropriate care. Then you flip the page and we begin talking about the other side of that coin, which is overutilization, ta da, da da, da da.

So clearly we can say that it alters choices. The subjective question is whether it's for the better or for the worse.

DR. WORZALA: If I can just say one more clarifying thing, I apologize. I'm hearing, Alice, in your comments that you thought that this slide was really about Medigap, and I didn't mean it that way. It's actually true for all sources of supplemental coverage. We're talking about employer-sponsored, Medigap, and Medicaid. They all have these same impacts, and I forgot to make that point.

MS. ROSENBLATT: In my reading of the text, I walked away with a definite impression that Medigap -- the takeaway message for me, in reading that chapter, was Medigap is bad. And I've got lots of paragraphs circled and I'll give it to you. Since I've got eight other points, I won't bother you all with the particular paragraphs.

Can I go on to the difference chart? The chart that says differences across sources of supplemental coverage.

Medigap eligibility restrictions. It says affordability. Affordability is an issue for all of these coverages. Somebody may turn down an employer-sponsored plan because they can't afford the contribution. They may not buy Medicare managed care because they can't afford the contribution. So I don't think it should appear just on Medigap.

Also, what's missing from this that was mentioned verbally is that Medigap is subject to open enrollment at age 65. In many states it's open enrollment all the time. It looks like everywhere there are issues of health status and disability. That's not true. There are also instances where if your employer takes actions or your Medicare managed care takes actions, there are laws that say you have to open enroll. So I think that's misleading.

The next thing on this table that I'm finding very confusing to understand is the comparison of premiums. I was really shocked when I saw these numbers. I think what may be going on

here is we've got so much variation by geography, by age, that we're getting lost in the averages and may be drawing conclusions that are not appropriate.

So I would suggest that we do some more work here. If we're going to compare across these different types of plans, I think we need to look at it consistently by area and age and see what that does.

DR. REISCHAUER: Do you really think these patterns would be affected?

MS. ROSENBLATT: I do.

DR. REISCHAUER: If I said let's do it for 65-year-old males in the Los Angeles metropolitan area, you don't think that the Medigap premium would be higher than the employer-sponsored and higher than the managed care? I mean, they might be different.

MS. ROSENBLATT: I'm just amazed at the extent of the difference. There's just something that doesn't look right to me.

DR. LAMBREW: Just a comment about that? There's been several places to go at this. One is looking at National Association of Insurance Commissioner data, which is where this particular number comes from.

MS. ROSENBLATT: I know, but it's national averages. I'm not saying that you picked up the wrong numbers. I'm just saying that sometimes averages are very misleading. I would like to see some analysis done by area.

MR. FEEZOR: On the employment-based monthly premiums, is that inclusive or non-inclusive of the Medicare Part B?

DR. LAMBREW: It does not include it. What's interesting is, I just learned this back in looking for it, 96 percent of employers do not cover that Medicare Part B. It's very uncommon that they include the Part B. So that's $50 on top of the $54.

MR. FEEZOR: Most of those plans, though, I would think are written so that you have to have Medicare Part B?

DR. LAMBREW: Correct.

MR. FEEZOR: So the out-of-pocket for 2002 would be another $54 up there? I was wondering if that would clarify Alice's point.

DR. REISCHAUER: That's true of all of these options.

MS. ROSENBLATT: The Part B would be left out of all of them, I think.

DR. LAMBREW: The only one that wouldn't be is Medicaid. Medicaid will pay for the Part B premium.

MS. ROSENBLATT: One of the things that you mentioned that I didn't see in the text but Scott, when you made the point that if Medicare is expanded, that might shrink the benefits that are offered through Medigap, which would lead to a decline in price. And I don't want to set up false expectations because the thing to understand is how does the trend compare to the decrease.

So you might not see the premium actually go down. You'd see less of an increase. Just a point there.

The other tone issue I had with the chapter was on the admin. It made it sound like Medicare is doing a great job at 2

percent admin and these terrible carriers are charging up to 35 percent. There are totally different distribution methods. I wouldn't say Medicare is doing a great job at 2 percent. I would say there's a lot of stuff Medicare should be doing that it's not, and that's why it's only 2 percent, like information systems and a whole bunch of stuff like that.

Also, there are some carriers mention the difficulty of the administrative interplay between the Medigap and the Medicare. There are some carriers that you only have to submit the bill once and that carrier takes care of the interplay between Medigap and Medicare, and it would be worth mentioning that.

Finally, I do agree with the issue that was brought up about the future retiree issue. I think that I agree, a lot of employers have taken the step to eliminate coverage for future employees, and that we will be seeing a more growing problem on that front.

Just a thought, we don't have any recommendations in here, but I want to suggest one that has to do with OBRA, because I think we've lived with that law for a very long time. It has created unintended consequences, and maybe it's time to make a recommendation about that.

I'm done.

DR. WAKEFIELD: I think this is for Jeanne, but if I'm incorrect, of course, any one of you.

Table 1 that's in the papers that we received in advance provides characteristics of Medicare beneficiaries. Obviously, as always, of interest to me the rural residents issue -- that shocks you, doesn't it Bob? You know, Bob, I'll stop raising rural the day you start raising it.

[Laughter.]

DR. WAKEFIELD: Or the day somebody else does.

DR. REISCHAUER: I need a site visit.

DR. WAKEFIELD: We've got one for you. It's 12 degrees below zero out there right now. You think about those little 82-year-olds bundled up in 12 below. They're tough.

I'm looking at residents, and it was my sense of this anyway, but it's interesting to me of course to see that really high reliance on Medigap. I guess I wouldn't have expected it to be quite that much difference between rural and urban. And also, the difference in terms of much higher numbers of rural residents relying on Medicare only. And then that higher Medicaid percentage.

So I guess I want to see if I'm drawing the right conclusions here. It seems to me that we've got far fewer choices across supplemental options, we always knew that, related to M+C for rural beneficiaries. You've got your employer-sponsored insurance column in here now, so that gives us some sense of what's happening there.

Fewer choices for Medicare beneficiaries, would it also be the case that it's likely we've got higher out-of-pocket expenses for rural Medicare beneficiaries, compared to their urban counterparts, when we think about what they're paying for in

terms of their supplemental insurance?

And then isn't that an important issue to be paying some attention to, given lower average incomes of rural beneficiaries versus urban beneficiaries? So I'm trying to get a sense of how serious a problem this represents, and difference, for rural versus urban beneficiaries.

DR. LAMBREW: I'm going to let Scott and Dan comment on the very explicit question about out-of-pocket spending, rural versus urban. But just two notes. You mention the lower income of rural beneficiaries. That, in part, explains why their disproportionately covered by Medicaid. That's a good thing in a way because there's drugs in Medicaid.

The bad news in this is that this chart is just about supplemental coverage. There have been studies done about prescription drug coverage among elderly and there also is this very large disparity because most of that Medigap coverage that these folks have does not have prescription drug coverage.

So that would suggest, since there's less prescription drug coverage and prescription drugs cost so much that there is a disproportionate hit. But these guys know the data.

DR. HARRISON: I think one factor on the employer-sponsored is that you tend to get smaller employers out in rural areas. I know we've been on site visits and we were told there's no employer-sponsored, there's no employers out there. So that's that answer.

DR. ROWE: There aren't any people out there, either.

[Laughter.]

DR. HARRISON: Dan, you're going to be doing this tomorrow, right?

DR. ZABINSKI: Here's what I know about urban versus rural out-of-pocket. On pure out-of-pocket spending, including out-of-pocket on premiums, rural and urban are almost identical on average. As far as percentage of income, I don't know. If rural beneficiaries have lower incomes on average, then if they have the same out-of-pocket then they're spending a higher share of their income on out-of-pocket. But I'd have to look into the data to see if that's true or not.

That's what I can tell you right now.

DR. WAKEFIELD: So your comment on out-of-pocket expenses being roughly the same equivalent between rural and urban beneficiaries, that's in terms of Medigap coverage? In terms of all supplemental coverage?

DR. ZABINSKI: Right, includes all premiums that they pay out-of-pocket, including the Part B premium, plus their out-of-pocket on services.

DR. NEWHOUSE: MedPAC actually has a history in this domain. As I recall, in our first year of existence, we recommended something called full replacement insurance only. Yes, you could sell supplemental insurance, but then you had to take the whole ball of wax. That fell like a tree in the forest with nobody in the forest, as far as I could tell. So let me try another potential option.

DR. REISCHAUER: Why don't you try another analogy?

[Laughter.]

DR. NEWHOUSE: I was going to suggest that we talk about an option -- Alice, as I hear her, wants to get rid of the OBRA '90 standardization all together. I think the OBRA '90 standardization was put in probably for good reason. The supplementary market was hopelessly muddled, I think, at that point. But the issue goes to what are the options that OBRA '90 allows. A decade has passed.

One option that I think is a little surprising to me that isn't there is a catastrophic only option. So you would buy a stop-loss policy. On the one hand, one could say that's going to promote selection, but there already is a ton of selection.

My objection to the premium numbers was not the premium numbers, just that they suppressed the tremendous amount of variation that's out there by geography, as you brought up. I agree with Bob's comment, that the same ordering would almost surely come through but it's really the variation that's out there.

But any event, the point I was going to make about the variation, is if you take a geographic area -- the data I've seen suggests that the premium difference between plans H and I -- let me say this. There's three plans that cover drugs, H, I, and J. H and I pay 50 percent to a $1,250 cap and J pays 50 percent to a $3,000 cap.

So we're talking about the benefit -- and there's very little other difference, I would say no material difference between those plans. So the extra benefit to somebody, at most, from picking J is 50 percent of $1,750. The premium differences that I've seen actually exceed $1,750.

MS. ROSENBLATT: Do you know why?

DR. NEWHOUSE: Tell me why. One answer has to be selection.

MS. ROSENBLATT: It is, and the law is forcing the rating to look plan by plan.

DR. NEWHOUSE: I would think the insurer would price that way anyway.

MS. ROSENBLATT: No, not necessarily. Some insurers were looking at their whole pool.

DR. NEWHOUSE: Then they could be undercut by an insurer that didn't offer all the plans. Going back to the catastrophic option only, this suggests that there's already an extreme amount of selection, even within the drug benefit, let alone the plans that offer drug benefits and the plans that don't.

Let me stop there and we can talk about that as a possible direction to head.

DR. LAMBREW: If I could just make a quick comment. The Balanced Budget Act of 1997 did create within plans C and F high deductible options. I think this is an old number -- those deductibles would be 15/80 -- in addition to the usual F plan which basically covers most of Medicare's cost-sharing, and the J plan which includes the $3,000 prescription drug benefit.

As far as I know, there's been very, very few plans who have

offered it and fewer people who have taken it, but those plan options do exist.

The second point I would just like to say quickly, on the issue about access to these Medigap plans, there haven't been that many states that have actually gone beyond what the OBRA standards are, in terms of guaranteeing access and doing any sort of rating reform. What we do know is that about 10 states have prohibited what's called attained age rating where you basically increase the premiums very rapidly with age. Six states have prohibited what's called entry age rating, which is a different way of rating that causes problems for some seniors. And only eight states have a version of community rating that are in place.

So it's not actually that common that you have these guarantees. And whereas BBA, the Balanced Budget Act of 1997, did provide some limited -- I call it transitional -- protections for people losing employer-sponsored insurance, going in and out of Medicare+Choice, unless their plan is open, the plan that they came from in Medigap, they often can only go back to a limited number of plans and can't get back into those plans with prescription drugs.

MS. ROSENBLATT: You also need to look at whether the rates are subject to prior approval.

DR. LAMBREW: Virtually all of the prescription drug options in Medigap are underwritten.

MS. NEWPORT: I found some of this very interesting. I've heard, and I think it's accurate, which may be reflected in the June report, that CMS is looking at plan K and L. I don't know much beyond that.

DR. REISCHAUER: The president suggested two catastrophic plans with drug benefits.

MR. FEEZOR: It's going to be called plan W.

[Laughter.]

MS. NEWPORT: I just want to make sure that when this comes out, if that's available, we should make sure it's in the report, in terms of what they are and what differences they may make.

I would like to know, if possible, on your graphs on the below poverty, medium income, and high income, what are the numbers of benes that are below poverty? What are we looking at, in terms of -- if it was in the text, I missed it.

DR. WORZALA: Table 1, I have 15 percent poor, 9 percent near poor.

MS. NEWPORT: Of all beneficiaries. Okay, I can do the math after that thank you.

I think that the assumption that changes in the scope of med sup coverage, lessening the scope of it would automatically lead to a reduction in premium. I don't think that's a direct line conclusion. I would bow to Alice on that one, I think that's absolutely right. And I think it has to do with all sorts of interactions, including amazing regional variability in just the types that are available. You may have two plans available in an area, particularly probably rural. Just helping you out.

DR. WAKEFIELD: Thank you.

MS. NEWPORT: I think the pre-ex condition, too, as Medicare+Choice has exited markets over the course of the last few years, there's no opportunities to automatically have a guaranteed issue. And those that are there, the pre-existing condition and the premiums and just a general availability of choice amongst med sup is diminished. So these are important points that have to continue to be brought out.

DR. ROWE: Just a couple of minor points. With respect to this monthly premium average that alarmed Alice. This $108 on Medigap, is that the average of A to J? Or is that a weighted average for the distribution of the beneficiaries in the different plans?

DR. HARRISON: It is weighted across all plans, including pre-standard plans.

DR. ROWE: So it is the actual average that the average person was paying in that year?

DR. HARRISON: Yes.

DR. ROWE: Secondly, each of these figures has a number on them or a year. I think we would all agree, if there's anything we would all agree on, that this is a fairly rapidly changing situation. And you started on unnumbered page number seven by telling -- and it would be helpful to number some of these once in a while for us.

This says source of coverage. This is a wheel. And you said that employer-sponsored coverage was the largest at 33. Then you said that Medigap was increasing as Medicare managed care was decreasing. So maybe that's higher than 28.

Then when you go to unnumbered page number 11, where it says percent of employers offering health coverage to Medicare eligible retirees has gone from 28 to 23 in two years.

DR. NEWHOUSE: This is employer-weighted.

DR. ROWE: I know. And my guess is that 2002 is lower than 23, which means that 33 is lower than it was.

DR. REISCHAUER: That's future. Most employers grandfather.

DR. ROWE: I understand, but I think it's lower and there are employers that don't grandfather everyone, et cetera.

So I think what would be very helpful, given the uncertainty with respect to a lot of this, is if you could draw a picture for us of what you estimate to be your current best guess of the distribution of this. '98 was a long time ago in a very rapidly changing set of variables.

DR. LAMBREW: I can just speak for myself personally, I'm not sure you all pay me enough to do that. That's a hard task.

DR. ROWE: Maybe one of our staff could, then.

[Laughter.]

DR. LAMBREW: I should actually say, before we leave, we did actually did spend some time thinking about this and we did some work that's implicit in some of the analyses you'll see subsequently. What we did was basically if you look at that decline in managed care enrollment between 1998 and 2002, it's about 1 million people.

There was a survey done in 1999 about what happens when people leave Medicare+Choice? Where do they go? This is something that Marsha Gold has done in her tremendous work on this topic. What they found was that 45 percent of those who don't go into another managed care plan go to Medigap. About 12 percent go to employer sponsored insurance. And what we think that is people who were both in employer-sponsored insurance and Medicare+Choice, so it's a reporting issue. About 18 percent go to some unnamed other source, probably also including Medicaid, and 24 percent of them become uncovered. They lose supplemental coverage.

So we took all of that and mushed it into the system. What you see is a small increase in the people without any type of coverage, from 9 percent to like 11 percent, and an increase in Medigap from like 28 to about 30 percent.

MR. HACKBARTH: So in all likelihood, Medigap will overtake employer-sponsored?

DR. ROWE: It doesn't really matter who's number one and number two. It's just that it would be nice to have a best estimate of what it looks like now for...

MR. HACKBARTH: I thought you were leading to some profound point.

DR. ROWE: No. Aetna is no longer interested in who or what is the largest. We're out of that business.

[Laughter.]

DR. ROWE: The other thing is I wanted to provide what I'm sure Alice meant with respect to Medigap reform. One of the things that seems to be distorting the market is the legislated standardization of Medigap during a period of time in which the market has changed a lot and Medigap hasn't been able to evolve, as I think was implicit in some of Alice's exceptionally excellent comments.

I do want to, in this little book that some of us have, Cliff's Notes on Medicare 2002, it says here in paragraph 640, under Medigap insurance, that Congress felt that Medigap insurance needed to be regulated because evidence indicated the companies marketing these policies often were guilty of unethical sales practices and other abuses. Furthermore, it was found the policies themselves often contained ineffective coverage, duplicated coverage already provided in Medicare, et cetera.

There was a reason why this bill was passed. I'm confident we would all agree that many of the aspects of the law that prohibit the sale of duplicated coverage, pre-existing condition limitations, suspension of Medigap premiums during Medicaid eligibility, et cetera, are all good things. We're not suggesting, I'm confident, that we want to get rid of any of those things.

Before anybody pushes back and says you can't get rid of that law because of all of these conditions, it really is the issue of the standardization of some of the nature of the benefits and premiums and things that has been restricted.

MS. ROSENBLATT: Thank you for the wonderful clarification,

Jack.

DR. ROWE: Before you get in trouble.

DR. BRAUN: One of the things I wanted to mention was that we need to remember that there's medical underwriting in most of the plans, but particularly in the drug plans. That cuts down on the adverse selection, because actually if you don't take it in the first six months then when you really need it you can't get it. So I'm sure there would be a lot more adverse selection if it were open.

The other thing is that not all the plans are in all of the areas. In fact, very few areas now are even offering the drug plans at all.

There was one other thing I did want to bring up, though. That was in the chapter -- fortunately I haven't heard the words this afternoon so you haven't seen flames coming out -- is risk averse. I think if we use the term risk averse, it's gotten a pejorative sense. I think that's very unfortunate.

But the fact is that the risk of expensive illness increases dramatically as one ages. Because the cost-sharing in Medicare is so irrational, prudence dictates that one recognize the high risk of incurring high expense and be prepared by carrying supplemental insurance. If the benefits were comprehensive and the cost-sharing were rational, as is the case with usual employee health benefits, this added insurance would be unnecessary.

It's really not first dollar coverage. I think that's the problem, risk averse and first dollar coverage get tied in together. It's not first dollar coverage as desired but protection from the high cost-sharing which is really high for inpatient hospitalization, for outpatient surgical and radiological procedures, SNF stays beyond 20 days, and so forth.

So Medicare beneficiaries who purchase Medigap are not risk averse consumers seeking first dollar coverage. They're simply prudent consumers who acknowledge the very high odds that they will experience an expensive illness or suffer from a chronic condition in the no longer distant future. And I count myself in that group.

[Laughter.]

MR. FEEZOR: Bea's observations did underscore one thing. I think Alice is right, that the market is working, and particularly given the restrictions it's working on, in terms of the supplemental market. I think as we get into this market we have moved from an insurance market to more of a prepayment or a budgeted plan of dealing with what is an increased certainty, as Bea points out. That's why I think we have a little different market dynamics than we have otherwise.

One of the things, just as an observation, and again this probably would not have been a part of this panel's study, but we're trying to deal with some of the creative things in our employment-based plan. And we look at the issue of maybe having the enrollee engage in payment out of, whether it's a spending account or personal care account.

One of the dynamics that drives us when we get to the retiree population is the fact that the current tax laws require active income and an employment base. Whereas, those of us who are still employed and have active income can, in fact, pay for some of our out-of-pocket cost and so forth on a prepayment basis, a pre-tax basis, and get the tax advantage.

And in the main that is not available to retirees. I would just simply put that out in terms of a policy reality. If we're talking about trying to refathom or reshape this thing, that's a significant barrier to some creativity.

DR. ROWE: There are a number of issues that limit the application of some of these products across the entire spectrum of beneficiaries, be they Medicare beneficiaries, pre-Medicare, medical, retiree, et cetera, that adjustments would open the market up considerably.

MR. SMITH: I assume that we need to wrap this up, so let me be very brief. Scott, I was struck in the criteria, in the discussion in the chapter, that there wasn't some attention paid to how the financial burden would be reallocated. If we change the benefit package, what ends up being paid by beneficiaries, what ends up being paid by government? Clearly, as you think about the effects on utilization, if we shift the utilization from something that is paid for by Part B or we shift utilization from something that's paid for by privately paid Medigap, the distribution of who pays for what -- both public and private, is going to change.

And as we think about the benefit package, I'm not sure what the principles are. Do we want to keep all the money that's in the system in the system? That's where I think I would start, but I'm not sure that that is the right principle. But we don't want to drive money out of the systems, I suspect.

So we ought to think about the impact of changes in the benefit package and the interaction between the public benefit package and the supplemental, in terms of where that money goes, and think about -- I would offer as a principle how do we keep that money in the system? But at least take account of that set of questions.

DR. HARRISON: I think you'll see some of that tomorrow.

MR. HACKBARTH: Chantal, were you trying to...

DR. WORZALA: Yes, I have more of a direction question, so maybe after Carol's comment.

MR. HACKBARTH: But she's not next.

[Laughter.]

DR. REISCHAUER: I'm concerned that Alice's initial eloquent salvo in defense of supplemental insurance is going to steer us away from what I think should be the very clear message of the report that we put out in June. And that is that an inadequate benefit package by Medicare leaves beneficiaries with two options. One is to be exposed to an unacceptable level of financial risk. And the other is to seek some form of supplemental insurance.

Most take that second option and inevitably, having two or

more sources of payment adds costs, complexities, and inequities to the system. And there's no way around it. It's not Alice's fault. It's not the employer's fault, in any sense. The original sin lies with the inadequate benefit package and there's no way to fix that.

I mean, you can screw around the edges and reduce the extra administrative costs a little bit and remove a little bit of the complexity, but it will always be there. It's why employers don't offer you six add-on insurance policies. They give you the choice of one. And that's where we should be going, especially when you find that virtually everybody has certain additional coverages.

90 percent have, through one form or another of supplemental insurance, have the hospital deductible covered. If that's true, why shouldn't we wrap it into Medicare, even if that means raising the premiums to do it? They're paying for it in a different way now.

MS. ROSENBLATT: I just want to respond to that. I don't entirely disagree with what you said, but I disagree with the payment issue. I disagree with the payment issue because you said they're paying for it anyway. In fact, they're not paying for it. They are paying for their supplemental insurance, but you have cross-generational funding going on for the basic Medicare package. So you have to be --

DR. REISCHAUER: They meaning -- somebody meaning the beneficiary is paying the Medigap premium. The employer is paying, probably by reducing the wages over time of the employees for the other. The general taxpayer is paying Medicaid. It's not, in a sense, new money that we would need. It's a redistribution of existing money, which is a very difficult thing to do, which is what Dave is going to talk about because you don't want it to be a windfall for employers.

MR. SMITH: Bob's exactly right, that's part of it. You don't want it to be a windfall for employers. One of the questions about a prescription drug benefit is there's a substantial amount of money already in the system, probably paid for by workers during their working lifetime, that a universal prescription drug benefit paid for by taxpayers would displace. That's irrational in an overall health system that is crimped for money.

I do think, Bob, you open up the right question but it is more complicated, I think, than saying that because Medicare beneficiaries are prepared to pay money for a supplemental benefit, that we ought to make that part of the basic benefit. It really does raise the sort of moral hazard issue that Chantal and Jeanne talked about, that if we make it part of the basic benefit what kind of Commissionutilization shifts do we get? How much of that is overutilization? How much of that is sensible and reasonable good health care policy?

But we shouldn't start with the presumption that because people are prepared to buy Medigap A, that it ought to be part of the benefit package.

DR. REISCHAUER: That's precisely why the example I used was the hospital deductible, because I don't think there's a big utilization problem there.

MR. SMITH: Right, but the hospital deductible is not the only thing that's covered by the supplemental stuff.

MS. RAPHAEL: I just wanted to make one point. If we look at supplemental as a way to offer financial protection as way as a way to possibly offer additional benefits for those who want to perhaps pay for it, I think that one of the things that I see is that as you put private and public dollars together, the private marketplace is a very unstable marketplace as you've described it.

And I think that that is important, for people to not have predictability. And it's on all of the dimensions. We have the Medicare+Choice program not offering stability, the employee retiree benefit is not a predictable benefit and it's subject to change. Medicaid clearly, in different states, is beginning to restrict and change eligibility. And the Medigap market, as well, is not to me a stable market.

I see that as an important factor in terms of trying to put this all together.

DR. ROSS: I don't want to distract the conversation, but I did want to give Jeanne the chance to answer a question that we are paying her enough to do an estimate for.

You mentioned on Medicaid, enrolled as a fraction of eligibles around 50 percent. Of that remaining 50, could you sort of parse that into what fraction you think is maybe measurement error, state unwillingness to cover, and people's unwillingness to enroll?

DR. LAMBREW: There have been some studies that have tried to delve into that, but the data limitations are huge. You basically can figure out what are the characteristics of those people. We do know that the people who do sign up are disproportionately minority, married and older. So we kind of know who's in and who's out of the group who's eligible.

But there are basically three reasons that are posited as to why this happens. One is lack of awareness, not that many people know that these benefits are out there. And there's been a stepped up effort in the last few years to increase that, but it still is fairly low in terms of awareness.

A second issue is states' willingness to really make this easy. Fewer than half of states actually have a simplified application, meaning it's not the 20-page application, it's a two-page application. Only about a third of states allow people to allow at sites other than welfare offices. We only have a few states, a handful of states, who have applications in any language other than English.

Those sorts of barriers make it difficult even for those people who know about the program to actually get into it. There are actually just two major reasons.

There's a third, which is the stigma issue, those who know about it but worry about being on welfare and will it be there

for them, has been a named reason but not very well studied amongst the elderly.

MS. RAPHAEL: Murray, just one point. In New York, after 9-11, there was a disaster Medicaid program put into effect where you could get Medicaid for four months. They reduced the application to one page. And within one week like 40,000 people enrolled. It made a huge difference.

DR. LAMBREW: Over the four month window, 380,000 people enrolled. And they actually have done a lot of studies saying that the simple ability to go in, sign up and get the card at the spot when you actually do this, rather than going through an application process, having your income verified, and waiting for the state to get back to you makes an enormous difference.

MR. HACKBARTH: I'm trying to think through where we might be headed, in terms of the changing dynamics of the supplemental market, employer-sponsored coverage, and the like. We start having -- and I may be getting in the way of Bea's flame thrower here -- too much of the wrong type of coverage for people. But now the prices are going up, whether the beneficiaries are paying it out of their own pocket for supplemental coverage or employers are paying on their behalf the prices are rapidly escalating.

Is it too much to hope that something good may come out of that and people may say well, as opposed to paying rapidly escalating premiums for the wrong type of coverage that pays small front-end sort of expenses, that they'll say well a way to reduce the cost of this is to not pay for that stuff that makes little sense from an insurance standpoint and move towards more catastrophic sort of coverage?

Joe's point about the selection issues would actually augment the move in that way because the catastrophic coverage tends to be underpriced relative to the other stuff because of selection issues.

So I'm searching through this pile of manure for the pony. Maybe some of these things will push us in the right direction. Am I totally off the mark?

DR. NEWHOUSE: Of course, you could do catastrophic through Medicare itself, which is where I thought Bob was headed, which takes us back to 1988. Or you can do it in the supplementary insurance market and we could lay those both out as options.

DR. REISCHAUER: I guess I have a problem with the discussion about the wrong kind of coverage. I mean, what Bea is saying, I think, and I agree with is that a lot of elderly people want to budget routine expenses that they know they're going to have, and 80 percent of them meet the Part B deductible, and they choose the supplemental way of going about doing it. I mean, it's like a Christmas club layaway plan or something like that. Each month you put a few bucks into it and it's better than having the $100 bill come in on January 11th, or whatever it is each year, and having to pay it.

MR. HACKBARTH: Although, to the extent it affects utilization patterns, that can be a more expensive way of paying for the services.

DR. REISCHAUER: But we're already in that situation at this point, and people want it. Is it the greatest sin in the world to swallow hard over this when we don't have immense amount of evidence about the induced utilization associated with this and we know that there's no way we're going to end wraparound policies by businesses for some important chunk -- 25 percent or so -- of the population? And it would be very inequitable to have the chosen few have this and nobody else be able to access it.

And so, even as an economist, I'd just swallow hard and give the people what they want.

DR. BRAUN: I don't believe they want first dollar coverage, but with these 10 plans they don't have much choice. If the plans were set up differently, I really think you might get a different response. I really think it's a very high coinsurance problem.

DR. REISCHAUER: They aren't buying plan A or plan B, which are the ones that don't give them the first dollar coverage. So I think they do want it.

MR. HACKBARTH: Jeanne's going to have the last word and then we're going to move on.

DR. LAMBREW: Chantal and I have a joint comment.

First of all, I think it's important to recognize with Medigap it was not Congress that set those Medigap plans. It was the National Association of Insurance Commissioners. And they did that trying to reflect what was common at the time and what might be good policy.

They have reconvened a working group to begin to reexamine these issues, although their major recommendation or concern is how do we do this in the absence of a Medicare drug benefit? Ten years later, when there's a lot of discussion about what do we do about prescription drugs, they're I think at a loss for what to do on that. And that's just reflecting the conversations that have been out there.

But to the point about the forced change, and going back to the fact that I was paid enough to do this so I will say it. Medigap inevitably is going to be an increasingly source of coverage for these folks, or there are going to be more people uncovered because we do know employer-sponsored insurance is going down. We do know Medicare+Choice is going down, although there's arguments about how much and how fast. Medicaid is just not going to expand much beyond where it is today, given its cost burden.

So it's going to be an inevitable choice. Either there's going to be more reliance on Medigap, maybe with changes, or there are going to be more people uncovered unless there's some sort of policy change like what Bob Reischauer was talking about.

MR. HACKBARTH: We need to move on to our next panel on total spending and sources of payment. Thank you, Jeanne.